

Tennessee Department of Health

Release of Protected Health Information

Patient's Name: \_\_\_\_\_

Patient's Number: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
(Name of Patient, Parent, or Guardian)

to use or disclose the following health information related to:

Myself    My Child \_\_\_\_\_    My Legal Ward \_\_\_\_\_  
(Name) (Name)

TYPE OF INFORMATION TO BE RELEASED: (Check and initial all that apply.)

All health department records **including** STD, HIV, Family Planning, and Substance Abuse

Immunization records \_\_\_\_\_

Family Planning records \_\_\_\_\_

All health department records **excluding** STD, HIV, Family Planning, and Substance Abuse

Genetic Testing records \_\_\_\_\_

STD records \_\_\_\_\_

Substance Abuse records (Federal regs require a description of amount and type of information to be disclosed.)  
Description: \_\_\_\_\_

HIV/AIDS records \_\_\_\_\_

Other records \_\_\_\_\_

The above information will be used/disclosed for the following purposes:

THE ABOVE INFORMATION IS TO BE RELEASED TO:

THE ABOVE INFORMATION IS TO BE RELEASED FROM:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

This release shall expire on \_\_\_\_\_  
Month Day Year

Signature of Patient/Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date \_\_\_\_\_

## NOTICE OF INDIVIDUAL RIGHTS

I understand I have the right to revoke this Authorization at any time, in writing, except to the extent the health department has taken action in reliance of the Authorization. I further understand a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand I may refuse to sign this Authorization. If I refuse to sign this Authorization, it will not affect my ability to otherwise receive treatment, payment, enrollment, or my eligibility for benefits, as applicable.

I understand the health department will furnish me with a signed copy of this Authorization.

I understand information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand I may inspect and/or obtain a copy of the health information to be used or disclosed as permitted under federal law and/or state law, whichever provides greater access rights.

Tennessee Department of Health's Notice of Privacy Practices has been provided or made available to me.

For disclosures of Substance Abuse records/information only:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**All medical records provided to the health department from another entity become an official part of the health department's records and are subject to release when properly requested.**